



GRETCHEN WHITMER
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
LANSING

MARLON I. BROWN, DPA
DIRECTOR

September 25, 2026

Nicholas Burnett
Flatrock Manor, Inc.
310 W. Oakley
Flint, MI 48503

RE: License #: AS250392270
Investigation #: 2026A0572047
Primrose

Dear Nicholas Burnett:

Attached is the Special Investigation Report for the above referenced facility. Due to the violations identified in the report, a written corrective action plan is required. The corrective action plan is due 15 days from the date of this letter and must include the following:

- How compliance with each rule will be achieved.
- Who is directly responsible for implementing the corrective action for each violation.
- Specific time frames for each violation as to when the correction will be completed or implemented.
- How continuing compliance will be maintained once compliance is achieved.
- The signature of the responsible party and a date.

If you desire technical assistance in addressing these issues, please feel free to contact me. In any event, the corrective action plan is due within 15 days. Failure to submit an acceptable corrective action plan will result in disciplinary action.

Please review the enclosed documentation for accuracy and contact me with any questions. In the event that I am not available and you need to speak to someone immediately, please contact the local office at (517) 643-7960.

Sincerely,

A handwritten signature in black ink that reads "Anthony Humphrey". The signature is written in a cursive style with a large, stylized 'A' and 'H'.

Anthony Humphrey, Licensing Consultant
Bureau of Community and Health Systems
411 Genesee
P.O. Box 5070
Saginaw, MI 48605
(810) 280-7718

enclosure

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY AND HEALTH SYSTEMS
SPECIAL INVESTIGATION REPORT**

I. IDENTIFYING INFORMATION

License #:	AS250392270
Investigation #:	2026A0572047
Complaint Receipt Date:	07/30/2026
Investigation Initiation Date:	08/03/2026
Report Due Date:	09/28/2026
Licensee Name:	Flatrock Manor, Inc.
Licensee Address:	310 W. Oakley St. Flint, MI 48503
Licensee Telephone #:	(810) 964-1430
Administrator:	Carrie Aldrich
Licensee Designee:	Nicholas Burnett
Name of Facility:	Primrose
Facility Address:	476 Primrose Flushing, MI 48433
Facility Telephone #:	(810) 877-6932
Original Issuance Date:	03/01/2018
License Status:	REGULAR
Effective Date:	09/01/2024
Expiration Date:	08/31/2026
Capacity:	6
Program Type:	DEVELOPMENTALLY DISABLED MENTALLY ILL

II. ALLEGATION(S)

	Violation Established?
Staff were informed that Resident A was not supposed to eat in order to receive a dental procedure on 07/14/2026. On the morning of Resident A's dental procedure, it was discovered that Resident A had eaten, costing the guardian \$700 in cancelation fees.	Yes

III. METHODOLOGY

07/30/2026	Special Investigation Intake 2026A0572047
08/03/2026	Special Investigation Initiated - Letter Complainant.
08/19/2026	Inspection Completed On-site Resident A, Scheduling Coordinator, Daire Chapman; Staff, Jalen Thomas; and Staff, Tiana Ferguson.
08/20/2026	Contact - Telephone call made Attempted phone call to Staff, Dae'Quan Laryea.
09/22/2026	Contact - Document Sent Complainant.
09/22/2026	Contact - Document Received Complainant.
09/25/2026	Contact - Telephone call made Staff, Dae'Quan Laryea.
09/25/2026	Contact - Telephone call made Resident A's Guardian.
09/25/2026	Exit Conference Licensee Designee, Nicholas Burnett.
09/25/2026	APS Referral An APS referral was made.

ALLEGATION:

Staff were informed that Resident A was not supposed to eat in order to receive a dental procedure on 07/14/2026. On the morning of Resident A's dental procedure, it was discovered that Resident A had eaten, costing the guardian \$700 in cancellation fees.

INVESTIGATION:

On 07/30/2026, the local licensing office received a complaint for investigation. Contact will be made with the Complainant regarding the allegation.

On 08/03/2026, an email was sent to the Complainant regarding any other additional information that could be shared regarding the allegation. Another contact will be made if there is no response.

On 08/19/2026, I made an unannounced onsite at Primrose, located in Genesee County Michigan. Interviewed were the following; Scheduling Coordinator, Daire Chapman; Staff, Jalen Thomas; and Staff, Tiana Ferguson. Resident A was also present in the home at the time of my onsite.

On 08/19/2026, I made face to face contact with Resident A. Resident A does not appear to be verbal. In my observation, Resident A was receiving adequate care and supervision. He was in his bedroom wearing a gray shirt and maroon colored pants.

On 08/19/2026, I interviewed Scheduling Coordinator, Daire Chapman regarding the allegation. Daire Chapman informed that Resident A had eaten a fruit cup, although he was not supposed to eat one that day. Resident A is food aggressive, so staff tried to prevent him from eating the fruit cup, but he had grabbed it from another resident's tray. Staff were able to take the fruit cup, but Resident A was still able to eat some of it. Resident A did not eat a lot of it, but it was enough for his appointment to be cancelled.

On 08/19/2026, I interviewed, Staff, Jalen Thomas regarding the allegation. Jalen Thomas says that he heard that Resident A had taken a fruit cup from another resident, but wasn't sure if he had eaten it, but his parents believed that he did. Resident A is very food aggressive and explained that he will attempt to take food and drinks from anyone if they have it within reach.

On 08/19/2026, I interviewed, Staff, Tiana Ferguson regarding the allegation. Tiana Ferguson informed that staff were preparing breakfast when Resident A walked out of his room and grabbed a fruit cup. His family had just walked into the home and saw Resident A with an empty fruit cup and assumed that he ate it. Tiana Ferguson did not witness Resident A eating the fruit cup. When his parents walked in, they explained to the staff that he was not supposed to eat or drink prior to his dental procedure and they cancelled the appointment.

On 08/20/2026, I made an attempt to contact Staff, Dae'Quan Laryea regarding the allegation. I did not receive an answer and will make a follow-up call in the coming days if I don't receive a call back.

On 09/22/2026, I contacted the Complainant regarding the allegation. The Complainant informed a staff had admitted to providing the fruit cup to Resident A but denied knowing about the medical directive. The information that Resident A was not to have anything to eat or drink was sent as a Teams message at 11:07 PM the night before by a manager named Monica McKeller. Out of the six-morning shift staff, only two were aware of the Teams message, and only one of those staff reported that they had read the message before their shift.

On 09/25/2026, I contacted Staff, Dae'Quan Laryea regarding the allegation. Dae'Quan Laryea informed that staff were not aware that Resident A had a dental procedure on the morning of 07/14/2026. 3rd shift never relayed anything to them and 3rd shift said that they were unaware of any communication from 2nd shift. At the time of the incident, staff were cooking breakfast when Resident A grabbed another resident's fruit cup. Resident A is known for grabbing other people's food, but staff were unaware of the dental procedure until Resident A's parents saw Resident A with a fruit cup. They informed staff that Resident A was not supposed to eat or drink prior to his procedure. Since Resident A is known for being food aggressive, I asked Dae'Quan Laryea what would have been done differently had staff known about the directive and the dental surgery, Dae'Quan Laryea informed that Resident A would not have been in the area to take anyone's food had they known. Staff would have kept him in his room or away from the dining area until it was time for him to leave for his appointment.

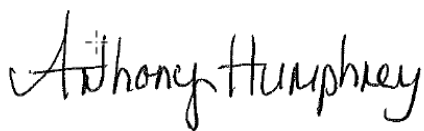
On 09/25/2026, I interviewed Resident A's Family Member #1 regarding the allegation. Family Member #1 informed that they had scheduled a Dentistry IV Sedation to repair Resident A's two front teeth. The sedation is due to Resident A's behavior. This procedure required Resident A not to eat nor drink for a period of 8 hours or from midnight until after his appointment had concluded. They were told that under no certain terms can Resident A miss his appointment because he's on the verge of losing his two front teeth. Because there were no dental surgeons who could complete this type of procedure nearby, it was very important that they not only make the appointment but also follow orders of the oral surgeon. Family Member #1 and #2 made a trip to the home just in case an issue would arise regarding the transport, so they would be there to transport if needed. When they walked into the home at 6:38 AM, Resident A was walking around with a fruit cup in his hand, and away from an empty plate. They explained to staff that Resident A had a dental procedure that morning and was not supposed to have any food or drink prior to his procedure. Family member #1 then contacted the dental office and explained what happened and they told them that they cannot do the procedure today as it puts Resident A at risk of aspiration and/or regurgitation.

On 09/25/2026, I held an exit conference with Licensee Designee, Nicholas Burnett regarding the results of my special investigation. Nicholas Burnett agreed with the findings and said that he will work on a corrective action plan regarding the staff communications.

APPLICABLE RULE	
R 400.689	Resident health care.
	(1) A licensee, with a resident's cooperation, shall follow the instructions and recommendations of a resident's physician or other designated health care professional.
ANALYSIS:	Based on my interviews with staff, Family Member #1 and the Complainant, there is enough evidence to establish a licensing rules violation. Many of the staff that worked the morning shift were not aware that Resident A had a dental procedure and was not supposed to eat. Resident A was seen eating a fruit cup that he had taken from another resident.
CONCLUSION:	VIOLATION ESTABLISHED

IV. RECOMMENDATION

I recommend that no changes be made to the license of this small adult foster care group home, pending the receipt of an acceptable corrective action plan (capacity 3-6).

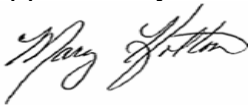


09/25/2026

Anthony Humphrey
Licensing Consultant

Date

Approved By:



09/25/2026

Mary E. Holton
Area Manager

Date